

ST. AUGUSTINE PREPARATORY SCHOOL

Authorization for medication to be given during school hours

CHILD'S NAME: _____

SCHOOL _____ **GRADE** _____

PHYSICIAN'S NAME _____ **ADDRESS** _____ **TELEPHONE** _____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as ordered by my physician (see below).

DATE _____ **PARENT/GUARDIAN SIGNATURE** _____ **HOME PHONE** _____ **EMERGENCY PHONE** _____

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is being given: _____

Name of Medicine _____

Form _____

Dose _____

If medication is to be given DAILY, at what time? _____

If medication is to be given PRN, how often? _____

How soon may the PRN medication be repeated? _____

Is this medication required to be administered on class trips? _____

List significant side effects: _____

Length of time medication is recommended: _____

Length of time medication is recommended: _____

Date: _____ Physician's Signature _____